ROCKY MOUNTAIN SENIOR CARE

Coding Guide

Revised 7-12-16

NURSING HOME - Initial Visit	CPT	Time*
Requires all 3 components (MDM/Hx/Exam)		
Straight/Low, 4x HPI & ROS x 2 sys, at least 1 hx, Exam 5-7	99304	25
Mod, 4x HPI &ROS x 10, PMFS (3Hx), Exam 8 or > sys	99304	35
High, 4x HPI &ROS x 10 PMFS (3Hx), Exam 8 or > sys	99306	45

NURSING HOME - Subsequent Visit	CPT	Time*
Requires all 2 of 3 components (MDM/Hx/Exam)		
Straight, 1-3 HPI & ROS x 1 sys	99307	10
Low, 1-3 HPI & ROS x 1 Exam 2-4 sys	99308	15
Mod, 4x HPI & ROS x 2 sys, at least 1 Hx, Exam 5-7 sys	99309	25
High, 4 x HPI & ROS x 10, PMFS (3 Hx), Exam 8 or > sys	99310	35

ASSISTED LIVING - NEW PT	CPT	Time*
Requires all 3 components (MDM/Hx/Exam)		
Straight, 1-3 HPI, ROS x 1 system, Exam x 1 sys	99324	20
Low, 1-3 HPI & ROS x 1 system, Exam 2-4 sys	99325	30
Mod, 4x HPI & ROS x 2 sys, at least 1 Hx, Exam 5-7 sys	99326	45
Mod, 4x HPI & ROS x 10, PMFS (3 Hx), Exam 8 or > sys	99327	60
High, 4 x HPI & ROS x 10, PMFS (3Hx), Exam 8 or > sys	99328	75

ASSISTED LIVING - EST PT	CPT	Time*
Requires all 2 of 3 components (MDM/Hx/Exam)		
Straight, 1-3 HPI & ROS x 1, Exam x 1 sys	99334	15
Low, 1-3 HPI & ROS x 1, Exam 2-4 sys	99335	25
Mod, 4x HPI & ROS x 2 sys, at least 1 Hx, Exam 5-7 sys	99336	40
High, 4 x HPI & ROS x 10, PMFS (3Hx), Exam 8 or > sys	99337	60

NURSING HOME DISCHARGE	CPT	Time*
Time must be documented		
Nursing Facility discharge day management < 30 minutes	99315	< 30
Nursing Facility discharge day management > 30 minutes	99316	> 30

NURSING HOME - Annual Visit	CPT	Time*
Requires all 3 components (MDM/Hx/Exam)		
Low/Mod, 4x HPI & ROS x 2 sys, at least 1 Hx, Exam 8 or > sys	99318	30

HOME - NEW PT	CPT	Time*
Requires all 3 components (MDM/Hx/Exam)		
Straight, 1-3 HPI, ROS x 1 system, Exam x 1 sys	99341	20
Low, 1-3 HPI & ROS x 1 system, Exam 2-4 sys	99342	30
Mod, 4x HPI & ROS x 2 sys, at least 1 Hx, Exam 5-7 sys	99343	45
Mod, 4x HPI & ROS x 10, PMFS (3 Hx), Exam 8 or > sys	99344	60
High, 4 x HPI & ROS x 10, PMFS (3Hx), Exam 8 or > sys	99345	75

HOME - EST PT	CPT	Time*
Requires all 2 of 3 components (MDM/Hx/Exam)		
Straight, 1-3 HPI & ROS x 1, Exam x 1 sys	99347	15
Low, 1-3 HPI & ROS x 1, Exam 2-4 sys	99348	25
Mod, 4 x HPI & ROS x 2 sys, at least 1 Hx, Exam 5-7 sys	99349	40
High, 4 x HPI & ROS x 10, PMFS (3 Hx), Exam 8 or > sys	99350	60

CHRONIC CARE MANAGEMENT	
Time must be documented	
99490	CCM, minimum 20 minutes to 60 minutes of clinical staff time/mo
99489	each additional 30 minutes/mo

CCM is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (2 or more), significant chronic care conditions expected to last at least 12 months, or until the death of the patient. In addition to other E/M visits (billed separately), these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff). The creation and revision of electronic care plans is also a key component of CCM.

ADVANCED CARE PLANNING	
Time must be documented	
99497	1st 30 minutes (min 16 minutes)
99498	each additional 30 minutes

Discussions may include all of the following points with the first three as required:

1. With whom the conversation was held (patient and/or surrogate)
2. The types of medical care preferred
3. The comfort level that is preferred
4. How the pateint preferes to be treated by others
5. What the patient wishes others to know

Because ACP is a time-based code, the documentation must include the total amount of time spent face-to-face with the patient, family members, and/or surrogate. For auditing purposes, start and stop times are the preferred method of documentation.

OPTUM ONLY SUPERVISION CODES	
Time must be documented	
99379	NP supervision 15-29 minutes
99380	NP Supervision 30 minutes or more

Supervision of a nursing facility patient (not present) requiring complex and multidisciplinary care modalities involving regular development and/or revisions to care plans, review of reports and patient status, review of laboratory and other studies, communication (including phone calls) for purposes of assessment of care decisions with other health care professionsal(s), family member(s), key caregivers, etc.

1995 Documentation Guidellines Utilized
MDM: straight (Straighforward), Low, Mod (moderate), and High
History: HPI (hx present illness), ROS (Rev of Sys), Hx (med/family/social)
Exam: Organ/Body Exam count

Novitas Exam: 4x4 Method
Detailed Exam = 4 body elements from 4 organ systems

TRANSITIONAL CARE MANAGEMENT	
Time must be documented	
99495	TCM Mod MDM w/in 14 days
99496	TCM High MDM w/in 7 days

TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living).

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (direct contact, telephone, electronic) withthe patient and/or caregiver within 2 business days of discharge
- Communication with home health agencies and other community services utilized by the patient
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents)
- Reviewing need for, or follow-up on, pending diagnostic tests and treatments
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems
- Education of patient, family, guardian, and/or caregiver
- Establishment or reestablishment of referrals and arrangement of needed community resources
- Assistance in scheduling any required follow-up with community providers and services

CODING BASED ON TIME *
Pub 100-4, Ch. 12, 30.6.1.C
When counseling and/or coordination of care dominates (more than 50%) the face-to-face provider/patient encounter or the floor time (in the case of NH/SNF services), time is the key or controlling factor in selecting the level of service.
Documentation Requirements:
1. Components of history, exam an MDM – even if cursory
2. Total Duration of the visit
3. Total duration of the counseling and/or coordination of care (More than 50%)
4. Describe the services provided in conjunction with MDM to support level of service billed.

See Typical Time* on grids by POS

Prolonged Care Services with Direct Patient Contact (99354-99357) Prolonged care services are billed separately when a provider spends over 30 minutes above the typical time allotted for any E/M encounter. Providers may count only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed. You can only bill for prolonged care services if the total duration equals or exceeds the threshold time (typical/average time associated with CPT E/M code plus 30 minutes)

Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based) When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be "rounded" to the next higher level. In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with **the highest code level in that family of codes** as the companion code

LACERATIONS

Simple/Superficial-Scalp, Neck, Axillae, External Genitalia, Trunk, Ext

12001	2.5 cm or less
12002	2.6 cm to 7.5 cm
12004	7.6 cm to 12.5 cm
12005	12.6 cm to 20.0 cm
12006	20.1 cm to 30.0 cm
12007	over 30.0 cm

Simple/Superficial-Face, Ears, Eyelids, Nose, Lips, Mucous Membranes

12011	2.5 cm or less
12013	2.6 cm to 5.0 cm
12014	5.1 cm to 7.5 cm
12015	7.6 cm to 12.5 cm
12016	12.6 cm to 20.0 cm
12017	20.1 cm to 30.0 cm
12018	over 30.0 cm

If a provider has placed sutures for a patient and the patient returns to the same provider for the suture removal, then the visit for the suture removal cannot be charged, because the removal is included in the initial laceration repair code. If a different provider placed the sutures, removal is bundled into the E/M visit.

	Code	Time	Threshold Times	
	E/M Code	Typical Time	99354	99354 and 99355
Office Services (POS 11) OFFICE				
New	99201	10	40	85
New	99202	20	50	95
Ne	99203	30	60	105
New	99204	45	75	120
New	99205	60	90	135
Est	99213	15	45	90
Est	99214	25	55	100
Est	99215	40	70	115
Home Services (POS 12) HOME				
New	99341	20	50	95
New	99342	30	60	105
New	99343	45	75	120
New	99344	60	90	135
New	99345	75	105	150
Est	99347	15	45	90
Est	99348	25	55	100
Est	99349	40	70	115
Est	99350	60	90	135
Domiciliary Services (POS 13) ALF				
New	99324	20	50	95
New	99325	30	60	105
New	99326	45	75	120
New	99327	60	90	135
New	99328	75	105	150
Est	99334	15	45	90
Est	99335	25	55	100
Est	99336	40	70	115
Est	99337	60	90	135
	E/M Code	Typical Time	99356	99356 and 99357
Nursing Home Services (POS 31) SNF & LTC				
Initial	99304	25	55	100
Initial	99305	35	65	110
Initial	99306	45	75	120
Sub	99307	10	40	85
Sub	99308	15	45	90
Sub	99309	25	55	100
Sub	99310	35	65	110
Annual	99318	30	60	105

PROCEDURES:

69210	Removal impacted cerumen requiring instrumentation, unilateral

Destruction Premalignant Lesions

17000	Destruction (e., cryosurgery) premalignant lesions (eg actinic keratoses), first lesion
17003	2nd - 14th Lesion, each (list separately in addition to 17000)
17004	15 or more lesions

JOINT: Arthrocentesis, aspiration and/or Inj

20600	**small joint or bursa** (eg, fingers, toes); without ultrasound guidance
20605	**intermediate joint or bursa** (eg, temporomandibular, acromioclavicular,

TUBES/LINES:

43760	Chang of gastrostomy tube, percutaneous w/o imaging oe endoscopic guidance
36569	Insert PICC; without subcutaneous port/pump
36589	Removal of **tunneled** PICC line without subcutaneous port/pump
	Removal of NON tunneled PICC line is included in E/M Service

I&D:

10061	I&D of abscess (eg carbuncle, cutaneous or subcutaneous abscess, cyst, furuncle or paronychia); complicated or multiple
10080	I&D of pilonidal cyst; simple
10081	I&D of pilonidal cyst; complicated
10120	Incision and removal of foreign body, subcutaneous; simple
10121	Incision and removal of foreign body, subcutaneous; complicated
49082	Abdominal paracentesis of ascities (diagnostic/therapeutic) without imaging guidance

IV HYDRATION ADMINISTRATION

96360	IV Hydration; initial 31 minutes to 1 hour
96361	IV Hydration; each additional hour
	IV hydration lasting less than 30 minutes is NOT reportable

SPLINTS

29105	Application of long arm splint (shoulder to hand)
29125	Application of short arm splint (forearm to hand); static
29126	Application of short arm splint (forearm to hand); dynamic
29130	Application of finger splint; static
29131	Application of finger splint; dynamic
64402	Injection, anesthetic agent, facial nerve block
51702	Insertion of temporary indwelling bladder catheter; simple (Foley)
	Removal is included in E/M Visit

SMOKING CESSATION COUNSELING

Symptomatic Patient; Time must be documented	
99406	Commercial Insurance; intermediate > than 3 minutes; up to 10 minutes
99407	Commercial Insurance; intensive, > 10 minutes
G0436	Medicare; intermediate > than 3 minutes; up to 10 minutes
G0437	Medicare; intensive, > 10 minutes

Proper documentation for tobacco-use cessation counseling should include the total time spent face to face with the patient, and what was discussed. The patient's desire or need to quit tobacco use, cessation techniques and resources, estimated quit date, and planned folllow-up should be noted in the medical record. Without this information, medical necessity for coverage may be questioned. Medicare will cover two cessation attempts per year. Each attempt may include a maximum of four intermediate or intensive sessions. Total annual benefit is 8 sessions per 12-month period.

Evaluation and management (E/M) tips/Key points to remember

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted

The key components (elements of service) of evaluation & management (E/M) services are: 1. History

2. Examination

3. Medical decision-making

4. Time (contributing-factor)

HOME CARE CERTIFICATION AND RECERTIFICATION

G0180	Certification
G0179	Recertification

Rules

- G0180 is billed only if the patient has not received Medicare Home Health services within last 60 days
- A face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care
- In situations when a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or NPP must see the patient within 30 days after
- Recertifications can be done every 60 days from time of initial certification
- Rare situations for "new plan of care" can allow for recertification before 60 days